

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01126

1124

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Talbot</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Caroline</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Federalburg</u> 05X-2	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Memorial Hospital</u>		d. STREET ADDRESS <u>Harmond Rd.</u>	
3. NAME OF DECEASED (Type or print) First <u>Winfield</u> Middle <u>S.</u> Last <u>Beall</u>		4. DATE OF DEATH Month <u>1</u> Day <u>26</u> Year <u>1959</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MAY 4, 1884</u>
9. AGE (In years last birthday) <u>74</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>John Beall</u>		14. MOTHER'S MAIDEN NAME <u>Lydia Perry</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Heart failure</u> <u>421.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Calcific aortic stenosis</u> DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1959</u> to <u>1959</u> , that I last saw the deceased alive on <u>12-26-59</u> , and that death occurred at <u>12:15 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>E. C. H. Schmidt</u>		ADDRESS (Street, city or town, state) <u>2195 Washington St. 26601-59</u>	
PHYSICIAN'S NAME (Type) <u>E. C. H. Schmidt</u>		DATE SIGNED <u>Jan 28 '59</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Rich S. McIntyre</u>		ADDRESS <u>Easton Market</u>	
24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE	
DATE <u>JAN 28 '59</u>		<u>Arthur E. Harris</u>	

[illegible]

## INSTRUCTIONS

**1** **TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 72 hours after death. The bottom copy may be retained by the hospital or attending physician.

**2** **TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS 15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01127

## CERTIFICATE OF DEATH

1150

Reg. Dist. No. ....

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>TALBOT</u>		STATE <u>MARYLAND</u>		COUNTY <u>CAROLINE</u>			
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>RURAL ST MICHAELS</u>		LENGTH OF STAY (in this place) <u>2 MOS</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>DENTON</u>		<u>05X-2</u> ✓	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
<b>3. NAME OF DECEASED</b> (Type or Print) <u>MARY</u> (First) <u>BOWMAN</u> (Middle) (Last)				<b>4. DATE OF DEATH</b> (Month) <u>JAN</u> (Day) <u>26</u> (Year) <u>1959</u>			
<b>5. SEX</b> <u>F</u>	<b>6. COLOR OR RACE</b> <u>W</u>	<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)</b> <u>Married</u>	<b>8. DATE OF BIRTH</b> <u>Nov 1855</u>	<b>9. AGE last birthday</b> <u>93</u> yrs.	<b>IF UNDER 1 YEAR</b> Months Days Hours Min.		<b>IF UNDER 24 HRS.</b> Hours Min.
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>none</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>at home</u>		<b>11. BIRTHPLACE</b> (State or foreign country) <u>Maryland</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>US</u>	
<b>13. FATHER'S NAME</b> <u>James Smith</u>				<b>14. MOTHER'S MAIDEN NAME</b> <u>Annie Woodall</u>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unk.)		<b>16. SOCIAL SECURITY NO.</b>		<b>17. INFORMANT &amp; ADDRESS</b> <u>Mrs. Wm. S. Orme, Denton, Del.</u>			
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>				<b>18. MEDICAL CERTIFICATION</b>			
<b>420.1 IMMEDIATE CAUSE (A)</b> <u>Coronary thrombosis</u>				<b>INTERVAL BETWEEN ONSET AND DEATH</b> <u>4 hr</u>			
<b>ANTECEDENT CAUSE(S) DUE TO</b>							
<b>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.</b> (B) <b>DUE TO</b>							
<b>(C)</b>							
<b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>				<u>Chronic atherosclerosis</u>			
<b>19a. DATE OF OPERATION</b>		<b>19b. MAJOR FINDINGS OF OPERATION</b>		<b>20. AUTOPSY?</b> YES <input type="checkbox"/> NO <input type="checkbox"/>			
<b>21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b>		<b>21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)</b>		<b>21c. WHERE DID INJURY OCCUR?</b> (City or town) (County) (State)			
<b>21d. TIME OF INJURY</b> (Month) (Day) (Year) (Hour) (Min.)		<b>21e. INJURY OCCURRED</b> White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		<b>21f. HOW DID INJURY OCCUR?</b>			
<b>22. I hereby certify that I attended the deceased from <u>July 25, 1958</u>, to <u>Jan 26, 1959</u>, that I last saw the deceased alive on <u>Jan 25, 1959</u>, and that death occurred at <u>11:22 A.M.</u> from the causes and on the date stated above.</b>							
<b>SIGNATURE</b> <u>Thos. H. Harrison</u>				<b>ADDRESS</b> (Street, city, town, state) <u>Easton, Maryland</u>			
<b>M.D.</b>				<b>DATE SIGNED</b> <u>26 Jan 59</u>			
<b>23. BURIAL, CREMATION, REMOVAL (SPECIFY)</b> <u>Burial</u>		<b>DATE THEREOF</b> <u>Jan 28, 1959</u>		<b>NAME OF CEMETERY OR CREMATORY</b> <u>Odd Fellows'</u>		<b>LOCATION</b> (City, town, or county) (State) <u>Camden, Del.</u>	
<b>24. REC'D BY REGISTRAR</b>		<b>REGISTRAR'S SIGNATURE</b>		<b>25. FUNERAL DIRECTOR'S SIGNATURE</b> <u>J. Virgil Moore</u>			
<b>DATE</b> <u>JAN 29 '59</u>				<b>ADDRESS</b> <u>Denton, Del.</u>			

# CERTIFICATE OF DEATH

Rev. Edw. M.D.

1120

1. NAME OF DECEASED (PRINT OR TYPE)

2. SEX (M or F)

3. DATE OF BIRTH (MONTH, DAY, YEAR)  
 4. PLACE OF BIRTH (CITY, STATE, COUNTRY)  
 5. OCCUPATION

6. MARITAL AND  
 7. STATUS OF DECEASED

8. DATE OF DEATH (MONTH, DAY, YEAR)  
 9. PLACE OF DEATH (CITY, STATE, COUNTRY)  
 10. CAUSE OF DEATH (PRINT OR TYPE)

11. SIGNATURE OF PHYSICIAN (PRINT OR TYPE)  
 12. SIGNATURE OF DECEASED (PRINT OR TYPE)

13. SIGNATURE OF WITNESS (PRINT OR TYPE)

14. SIGNATURE OF DECEASED (PRINT OR TYPE)

15. SIGNATURE OF DECEASED (PRINT OR TYPE)

16. SIGNATURE OF DECEASED (PRINT OR TYPE)

17. SIGNATURE OF DECEASED (PRINT OR TYPE)

18. SIGNATURE OF DECEASED (PRINT OR TYPE)

19. SIGNATURE OF DECEASED (PRINT OR TYPE)

20. SIGNATURE OF DECEASED (PRINT OR TYPE)

21. SIGNATURE OF DECEASED (PRINT OR TYPE)

22. SIGNATURE OF DECEASED (PRINT OR TYPE)

23. SIGNATURE OF DECEASED (PRINT OR TYPE)

24. SIGNATURE OF DECEASED (PRINT OR TYPE)

25. SIGNATURE OF DECEASED (PRINT OR TYPE)

26. SIGNATURE OF DECEASED (PRINT OR TYPE)

27. SIGNATURE OF DECEASED (PRINT OR TYPE)

28. SIGNATURE OF DECEASED (PRINT OR TYPE)

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37. SIGNATURE OF DECEASED (PRINT OR TYPE)

38. SIGNATURE OF DECEASED (PRINT OR TYPE)

39. SIGNATURE OF DECEASED (PRINT OR TYPE)

40. SIGNATURE OF DECEASED (PRINT OR TYPE)

41. SIGNATURE OF DECEASED (PRINT OR TYPE)

42. SIGNATURE OF DECEASED (PRINT OR TYPE)

43. SIGNATURE OF DECEASED (PRINT OR TYPE)

44. SIGNATURE OF DECEASED (PRINT OR TYPE)

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47. SIGNATURE OF DECEASED (PRINT OR TYPE)

48. SIGNATURE OF DECEASED (PRINT OR TYPE)

49. SIGNATURE OF DECEASED (PRINT OR TYPE)

50. SIGNATURE OF DECEASED (PRINT OR TYPE)

51. SIGNATURE OF DECEASED (PRINT OR TYPE)

52. SIGNATURE OF DECEASED (PRINT OR TYPE)

53. SIGNATURE OF DECEASED (PRINT OR TYPE)

FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01128

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Talbot</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Trappe RD</b> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MD</b> b. COUNTY <b>Talbot</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Trappe RD</b> d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Delena</b> First <b>ANN</b> Middle <b>BROOKS</b> Last 4. DATE OF DEATH <b>Jan 5 1959</b> Month Day Year		5. SEX <b>F</b> 6. COLOR OR RACE <b>C</b> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <b>Dec 18, 1958</b> yrs. Months Days 9. AGE (In years last birthday) <b>78</b> yrs. Months Days 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) 11. BIRTHPLACE (State or foreign country) <b>Maryland</b> 12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Eugene Brooks</b> 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) 16. SOCIAL SECURITY NO. 17. INFORMANT <b>Doris Brooks</b> Address <b>Trappe RD Md.</b>		18. CAUSE OF DEATH [Enter only one cause, or line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Broncho-pneumonia</b> <b>763.0</b> DUE TO <b>U.R.I. - 1 wk</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year <b>Jan 5 1959</b> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE <b>Lewis Welch</b> M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) <b>WELCH</b> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED <b>1-5-59</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b> 22b. DATE THEREOF <b>1-7-59</b> 22c. NAME OF CEMETERY OR CREMATORY <b>Williamson Co</b> 22d. LOCATION (City, town, or county) (State) <b>Easton Md.</b>		23. FUNERAL DIRECTOR'S SIGNATURE <b>James D. Doherty</b> ADDRESS <b>Easton, Md.</b> 24a. REC'D BY REGISTRAR <b>JAN 8 1959</b> 24b. REGISTRAR'S SIGNATURE <b>Arthur S. Evans</b>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for the files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, at its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.





## CERTIFICATE OF DEATH

01129

Reg. Dist. No.

1152

1. PLACE OF DEATH a. COUNTY <b>Talbot</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Talbot</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>St. Michaels</b>				c. LENGTH OF STAY IN 1b <b>life</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Rio Vista Nursing Home</b>				d. STREET ADDRESS <b>St. Michaels</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <b>George</b> Middle <b>Conner</b> Last <b>Conner</b>				4. DATE OF DEATH Month <b>January</b> Day <b>8</b> Year <b>1959</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>April 9, 1878</b>		9. AGE (In years last birthday) <b>80</b> yrs.	IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min.	IF UNDER 24 HRS. Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Waterman</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Seafood</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>u s a</b>	
13. FATHER'S NAME <b>Thomas Conner</b>				14. MOTHER'S MAIDEN NAME <b>Martha Jewell</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT <b>Earl Conner 1806 No. Gay Balto 13 Md</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>subarachnoid hemorrhage</b> <b>330x</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>atherosclerotic cerebrovascular</b> DUE TO (c) <b>—</b>							INTERVAL BETWEEN ONSET AND DEATH <b>Immediate</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) <b>Hypertension, Essential vascular</b>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)		(County)	(State)	
21. I certify that I attended the deceased from <b>11-17</b> , 19 <b>54</b> to <b>1-8</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>1-8</b> , 19 <b>59</b> , and that death occurred at <b>1:30</b> P.M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>St Michaels Md</b> DATE SIGNED <b>1-9-59</b>							
ACTUAL SIGNATURE <b>Guy M. Rogers</b>		PHYSICIAN'S NAME (Type) <b>Guy M. Rogers</b>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>Jan. 10, 1959</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Springhill</b>		22d. LOCATION (City, town, or county) <b>Easton, Md.</b>		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Norman D. Marshall - St. Michaels, Md</b>				24a. RECD BY REGISTRAR <b>JAN 13 59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

DECEASED'S NAME		DATE OF BIRTH	
SEX		AGE	
RACE		EDUCATION	
MARRIED		OCCUPATION	
PLACE OF BIRTH		PLACE OF DEATH	
DATE OF DEATH		TIME OF DEATH	
CAUSE OF DEATH		MANNER OF DEATH	
SIGNATURE OF PHYSICIAN		SIGNATURE OF WITNESS	
DATE		TIME	
PLACE		CITY	
STATE		COUNTY	
ZIP CODE		FEDERAL ID NUMBER	
LOCAL ID NUMBER		NATIONAL ID NUMBER	
MIDDLE INITIAL		LAST NAME	
FIRST NAME		MIDDLE NAME	
DATE OF BIRTH		TIME OF BIRTH	
PLACE OF BIRTH		PLACE OF DEATH	
DATE OF DEATH		TIME OF DEATH	
CAUSE OF DEATH		MANNER OF DEATH	
SIGNATURE OF PHYSICIAN		SIGNATURE OF WITNESS	
DATE		TIME	
PLACE		CITY	
STATE		COUNTY	
ZIP CODE		FEDERAL ID NUMBER	
LOCAL ID NUMBER		NATIONAL ID NUMBER	
MIDDLE INITIAL		LAST NAME	
FIRST NAME		MIDDLE NAME	

1. I hereby certify that the above is a true and correct copy of the original certificate of death as filed in the office of the Registrar of the State Department of Health.

2. I hereby certify that the above is a true and correct copy of the original certificate of death as filed in the office of the Registrar of the State Department of Health.

3. I hereby certify that the above is a true and correct copy of the original certificate of death as filed in the office of the Registrar of the State Department of Health.

4. I hereby certify that the above is a true and correct copy of the original certificate of death as filed in the office of the Registrar of the State Department of Health.

5. I hereby certify that the above is a true and correct copy of the original certificate of death as filed in the office of the Registrar of the State Department of Health.

6. I hereby certify that the above is a true and correct copy of the original certificate of death as filed in the office of the Registrar of the State Department of Health.

7. I hereby certify that the above is a true and correct copy of the original certificate of death as filed in the office of the Registrar of the State Department of Health.

8. I hereby certify that the above is a true and correct copy of the original certificate of death as filed in the office of the Registrar of the State Department of Health.

9. I hereby certify that the above is a true and correct copy of the original certificate of death as filed in the office of the Registrar of the State Department of Health.

10. I hereby certify that the above is a true and correct copy of the original certificate of death as filed in the office of the Registrar of the State Department of Health.



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01130

## CERTIFICATE OF DEATH

Reg. Dist. No.

1125

1. PLACE OF DEATH a. COUNTY <u>Talbot</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Talbot</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>40 Easton</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Memorial Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Baby Boy</u> Middle <u>Cook</u> Last <u>Cook</u>				4. DATE OF DEATH Month <u>January</u> Day <u>23</u> Year <u>1959</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>Col</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>January 23, 1959</u>		9. AGE (In years last birthday) yrs. <u>11</u> Months <u>11</u> Days <u>30</u>		IF UNDER 1 YEAR IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Jerome Gilbert Cook</u>				14. MOTHER'S MAIDEN NAME <u>Barbara Viola Miller</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Barbara Cook</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>776X Prematurity</u> DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) _____ DUE TO (d) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH <u>12 hrs.</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Jan. 23</u> , 19 <u>59</u> , to <u>Jan. 23</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>Jan. 23</u> , 19 <u>59</u> , and that death occurred at <u>5:30 P.</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Donald J. Butler</u> M.D.				ADDRESS (Street, city or town, state) <u>911 HANSON ST. EASTON, MD</u>		DATE SIGNED <u>1-23-59</u>	
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town or county) (State)	
<u>Incineration</u>		<u>1/25/59</u>		<u>Memorial Hospital</u>		<u>Easton Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE				ADDRESS		24a. REC'D BY REGISTRAR DATE <u>JAN 29 '59</u>	
						24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kraus</u>	

2080203XVO

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
Item 14 Film G238 1-23-59 et  
1126  
CERTIFICATE OF DEATH

01131

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>TALBOT</b> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>CAROLINE</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>ESTON</b>			c. LENGTH OF STAY In: 1 wk			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>MEMORIAL HOSP.</b>			d. STREET ADDRESS <b>05 X - 2</b>			
3. NAME OF DECEASED (Type or print) First <b>AGNES</b> Middle <b>CROUSE</b> Last <b>CROUSE</b>			4. DATE OF DEATH Month <b>JAN</b> Day <b>13</b> Year <b>1959</b>			
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>MAR 29, 1890</b>	9. AGE (In years last birthday) <b>68</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>house</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>house</b>			
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>			12. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
13. FATHER'S NAME <b>EMMANUEL KING</b>			14. MOTHER'S MAIDEN NAME <b>Unknown</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.			
17. INFORMANT <b>Donald Crouse</b> Address <b>Ridgely Md</b>						
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>452x</b> <b>Choccal embolism</b> DUE TO <b>Heart attack into neck</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Rupture of aneurysm</b> (c) <b>Obesity</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Obesity</b>						INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. ft. p. m. <b>19</b>			20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>1959</b> to <b>1959</b> , that I last saw the deceased alive on <b>1959</b> , and that death occurred at <b>1959</b> M, from the causes and on the date stated above.						
ACTUAL SIGNATURE <b>E. C. H. Schmidt</b>			M.D. <b>2195 Washington St 15 Jan 59</b>			
PHYSICIAN'S NAME (Type) <b>E. C. H. Schmidt</b>			Address <b>Easton 16, Maryland</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Jan 17, 1959</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Denton</b>		
22d. LOCATION (City, town, or county) <b>Denton, Md</b>		(State)				
23. FUNERAL DIRECTOR'S SIGNATURE <b>J. Vergil Morehead</b>			ADDRESS <b>Denton</b>			
24a. REC'D BY REGISTRAR <b>AN 19 '59</b>			24b. REGISTRAR'S SIGNATURE <b>Arthur S. Harris</b>			

# MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 13 CERTIFICATE OF DEATH

NAME OF DECEASED		DATE OF DEATH	
HUSBAND		1914	
PLACE OF DEATH		CITY	
CITY		COUNTY	
STATE		COUNTRY	
AGE		SEX	
RACE		RELIGION	
EDUCATION		OCCUPATION	
MARRIAGE		PREVIOUS MARRIAGES	
CAUSE OF DEATH		MANNER OF DEATH	
DISEASE		INJURY	
SYMPTOMS		TREATMENT	
HISTORY		FAMILY HISTORY	
SOCIAL HISTORY		HABITS	
PERSONALITY		MENTAL STATE	
PHYSICAL EXAMINATION		LABORATORY EXAMINATIONS	
PATHOLOGICAL FINDINGS		MICROSCOPIC FINDINGS	
GROSS FINDINGS		HISTOLOGICAL FINDINGS	
BACTERIOLOGICAL FINDINGS		SEROLOGICAL FINDINGS	
X-RAY FINDINGS		OTHER FINDINGS	
POST-MORTEM FINDINGS		CAUSE OF DEATH (REPEATED)	
MANNER OF DEATH (REPEATED)		SIGNATURE OF PHYSICIAN	
SIGNATURE OF CORONER		SIGNATURE OF JURY	
SIGNATURE OF WITNESSES		SIGNATURE OF DECEASED	
SIGNATURE OF FUNERAL HOME		SIGNATURE OF BURIAL PLACE	
SIGNATURE OF HEALTH DEPARTMENT		SIGNATURE OF BALTIMORE CITY	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the registrar, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# Item 1 FilmG237 1-19-59 et 1127 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 CERTIFICATE OF DEATH

01132

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Talbot</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Talbot</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>40 Easton</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Death did not occur in an</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>James</u> Middle <u>Willard</u> Last <u>Davis</u>				4. DATE OF DEATH Month <u>Jan</u> Day <u>8</u> Year <u>1959</u>			
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Mar 3, 1892</u>	
9. AGE (In years last birthday) <u>66</u> yrs.		IF UNDER 1 YEAR Months <u></u> Days <u></u> Hours <u></u> Min. <u></u>		IF UNDER 24 HRS. Months <u></u> Days <u></u> Hours <u></u> Min. <u></u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>School Supt.</u>			
11. BIRTHPLACE (State or foreign country) <u>Talbot Co., Maryland</u>				12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>			
13. FATHER'S NAME <u>Frank Davis</u>				14. MOTHER'S MAIDEN NAME <u>Ellen J. Davis</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>None</u>			
17. INFORMANT <u>Mrs. W. Davis</u> Address <u>Easton</u>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ACUTE MYOCARDIAL INFARCTION</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>ARTERIOSCLEROTIC HEART DISEASE</u> DUE TO (c) <u></u>							
INTERVAL BETWEEN ONSET AND DEATH <u>INSTANT</u> <u>3 yrs.</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>Sept</u> , 19 <u>55</u> , to <u>Jan</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>2 Jan</u> , 19 <u>59</u> , and that death occurred at <u>7:00 AM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Easton, Maryland</u> DATE SIGNED <u>1:10:59</u>							
ACTUAL SIGNATURE <u>Shepard K. Ketch Jr.</u> M.D. <u>Easton, Maryland</u>							
PHYSICIAN'S NAME (Type) <u>SHEPARD KETCH JR</u> <u>EASTON</u> <u>Maryland</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>None</u>		<u>Jan 10, 59</u>		<u>St. Mary's</u>		<u>Easton</u> <u>MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Richard</u> ADDRESS <u>Easton</u>				24a. REC'D BY REGISTRAR DATE <u>Jan 13 59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Thayer</u>	







1128

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Talbot</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Queen Anne</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Queens town</u>	
c. LENGTH OF STAY IN 1b <u>18 days</u>		d. STREET ADDRESS <u>17X-2</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Memorial Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Ralph</u> Middle <u>E</u> Last <u>Dutcher</u>		4. DATE OF DEATH Month <u>January</u> Day <u>7</u> Year <u>1959</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 2, 1889</u>
9. AGE (In years last birthday) <u>69</u> yrs.		10. IF UNDER 1 YEAR: Months <u>6</u> Days <u>17</u> Hours <u>2</u> Min. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Contractor</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Kansas</u>	
11. BIRTHPLACE (State or foreign country) <u>Kansas</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>George Dutcher</u>		14. MOTHER'S MAIDEN NAME <u>Flora Russell</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>unknown</u>		16. SOCIAL SECURITY NO. <u>unknown</u>	
17. INFORMANT <u>Hospital Records</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral thrombosis - left hemiplegia</u> 332X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>cerebral atherosclerosis</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Cerebral atherosclerosis</u> INTERVAL BETWEEN ONSET AND DEATH <u>18 days</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>20 Dec</u> 19 <u>58</u> to <u>2 Jan</u> 19 <u>59</u> , that I last saw the deceased alive on <u>7 Jan</u> 19 <u>59</u> , and that death occurred at <u>3:35 PM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Easton, Maryland</u> DATE SIGNED <u>7 Jan 59</u> ACTUAL SIGNATURE <u>Thorston Harrison</u> M.D. PHYSICIAN'S NAME (Type) <u>THORSTON HARRISON</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>1/9/59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>FT. LINCOLN MAUSOLEUM PRINCE GEORGES'S CO. MD.</u>	22d. LOCATION (City, town, or county) (State)
23. FUNERAL DIRECTOR'S SIGNATURE <u>The S. H. Prince Co</u> ADDRESS <u>2901-14th St. N.W. Wash. D.C.</u>		24a. REC'D BY REGISTRAR DATE <u>JAN 9 '59</u>	24b. REGISTRAR'S SIGNATURE <u>Charles S. House</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

PLACE OF BIRTH (State, Territory, Possession, Country, etc.)		MARITAL STATUS (Single, Married, Widowed, Divorced, etc.)	
DATE OF BIRTH (Month, Day, Year)		PLACE OF DEATH (City, Town, Village, etc.)	
SEX (Male, Female)		OCCUPATION (Profession, Trade, etc.)	
COLOR (White, Black, etc.)		CAUSE OF DEATH (Disease, Injury, etc.)	
TIME OF DEATH (Hour, Minute)		PLACE OF INTERMENT (Cemetery, etc.)	
SIGNATURE OF DECEASED (If known)		SIGNATURE OF WITNESSES (Two or more persons)	
SIGNATURE OF PHYSICIAN (If known)		SIGNATURE OF CLERK (If known)	
SIGNATURE OF REGISTRAR (If known)		SIGNATURE OF JUDGE (If known)	
SIGNATURE OF SHERIFF (If known)		SIGNATURE OF CLERK (If known)	
SIGNATURE OF DECEASED (If known)		SIGNATURE OF WITNESSES (Two or more persons)	
SIGNATURE OF PHYSICIAN (If known)		SIGNATURE OF CLERK (If known)	
SIGNATURE OF REGISTRAR (If known)		SIGNATURE OF JUDGE (If known)	
SIGNATURE OF SHERIFF (If known)		SIGNATURE OF CLERK (If known)	

RECEIVED  
 DEPARTMENT OF HEALTH  
 BATHING CURE 18

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03548

1129

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>TALBOT</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>TALBOT</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>EASTON</u>		c. LENGTH OF STAY IN TB <u>42 hr.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Memorial Hospital</u>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>x EASTON</u>	
3. NAME OF DECEASED (Type or print) First <u>Susie</u> Middle <u>A.</u> Last <u>Dyott</u>		4. DATE OF DEATH Month <u>Jan.</u> Day <u>29</u> Year <u>1959</u>	
5. SEX <u>fe</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MAR 20, 1893</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWORK</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>HOUSEWIFE</u>	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>William Duval</u>		14. MOTHER'S MAIDEN NAME <u>Ellie Collins</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service) <u>NONE</u>		16. SOCIAL SECURITY NO. <u>UNK.</u>	
17. INFORMANT <u>JAMES T. Dyott, EASTON, R.D. MD</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Encephalomalacia, recent &amp; old -</u> <u>332X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Myocardial Infarct</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Jan. 29</u> , 19 <u>59</u> , to <u>Jan. 29</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>Jan. 29</u> , 19 <u>59</u> , and that death occurred at <u>12:30 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>E. C. H. Schmidt</u>		M.D. <u>219 S. Washington St</u> ADDRESS (Street, city or town, state) DATE SIGNED <u>Jan 29 1959</u>	
PHYSICIAN'S NAME (Type) <u>E. C. H. Schmidt</u>		ADDRESS <u>Easton, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>2/2/59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>WOODLAWN MEM.</u>	22d. LOCATION (City, town, or county) (State) <u>EASTON, MD.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. H. Carroll</u>		ADDRESS <u>Easton, MD.</u>	
24a. REC'D BY REGISTRAR <u>APR 1 1959</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Jones</u>	



1130

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Talbot</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Talbot</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Easton</b>				c. LENGTH OF STAY IN TB <b>5 yrs</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>412 Goldsboro St.</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Katie</b> Middle <b>Colgan</b> Last <b>Gibson</b>				4. DATE OF DEATH Month <b>January</b> Day <b>22</b> Year <b>19 59</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>May 2, 1881</b>	
9. AGE (In years last birthday) <b>77</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housework</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Housewife</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>							
13. FATHER'S NAME <b>Unknown</b>				14. MOTHER'S MAIDEN NAME <b>Unknown</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>unknown --</b>				16. SOCIAL SECURITY NO. <b>220-01-6388</b>			
17. INFORMANT <b>412 Goldsboro St.</b>				18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic Heart Disease</b> 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>June</b> , 19 <b>57</b> , to <b>Jan 22</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>Jan. 22</b> , 19 <b>59</b> , and that death occurred at <b>5 P.M.</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Donald F. Bartley</b> M.D.				ADDRESS (Street, city or town, state) <b>9 N. HANSON ST.</b> DATE SIGNED <b>1-23-59</b>			
PHYSICIAN'S NAME (Type) <b>DONALD F. BARTLEY M.D.</b>				<b>EASTON, M.D.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>1/26/59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Oxford Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Oxford Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>W. H. Thompson</b>				24a. REC'D BY REGISTRAR <b>Jan 27 '59</b>			
ADDRESS <b>Easton, Maryland</b>				24b. REGISTRAR'S SIGNATURE <b>Wm. H. Thompson</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# CERTIFICATE OF DEATH

1120

MATLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 18

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1131

CERTIFICATE OF DEATH

01135

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Talbot</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md.</u> b. COUNTY <u>Talbot</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>				c. LENGTH OF STAY IN 1b <u>24 hrs</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Memorial Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Helen</u> Middle <u>Haddaway</u> Last <u>Haddaway</u>				4. DATE OF DEATH Month <u>January</u> Day <u>10</u> Year <u>1959</u>			
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>January 8, 1900</u>	
9. AGE (In years last birthday) <u>59</u> yrs.		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>		IF UNDER 24 HRS. Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Hw.</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>		11. BIRTHPLACE (State or foreign country) <u>md.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>Charles E. Haddaway</u>				14. MOTHER'S MAIDEN NAME <u>Lillian Wayman</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service) <u>-</u>				16. SOCIAL SECURITY NO. <u>-</u>			
17. INFORMANT <u>James J. Haddaway Jr. Neavitt Md</u>				Address <u>-</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Heart failure</u> <u>420.1</u> DUE TO <u>Myocardial Infarction</u> Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. (b) <u>Coronary occlusion</u> DUE TO (c) <u>-</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>-</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>19</u> to <u>19</u> , that I last saw the deceased alive on <u>1-13-59</u> and that death occurred at <u>7:30</u> P. M. from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>E. C. H. Schmidt</u> M.D.				DATE SIGNED <u>1/11/59</u>			
PHYSICIAN'S NAME (Type) <u>E. C. H. Schmidt</u>				ADDRESS <u>219 S. Washington St. Easton, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>1-13-59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Neavitt Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Neavitt, md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>H. J. Hambleton</u> ADDRESS <u>Hawthorne, St. Michaels, md.</u>				24a. REC'D BY REGISTRAR DATE <u>JAN 13 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kneel</u>	



FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
BM 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18										01138
MEDICAL EXAMINER'S CERTIFICATE OF DEATH										Reg. Dist. No.
1. PLACE OF DEATH a. COUNTY <b>TALBOT</b> <b>MARYLAND</b>					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>TALBOT</b>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>TRAPPE RURAL</b>			c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>TRAPPE RURAL</b>					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)					d. STREET ADDRESS					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>MILDRED</b> Middle <b>BRERWOOD</b> Last <b>HIGHLEY</b>					4. DATE OF DEATH Month <b>JAN</b> Day <b>12</b> Year <b>1959</b>					
5. SEX <b>F</b>		6. COLOR OR RACE <b>W</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>June 21, 1906</b>		9. AGE (In years last birthday) <b>52</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>					10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY <b>USA</b>	
13. FATHER'S NAME <b>Charles W. Brerewood</b>					14. MOTHER'S MAIDEN NAME <b>Willie Mills</b>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>A B Highley Trappe Maryland</b>						
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>/pending autopsy/ Acute alcoholism</b> <b>322.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>0.29%</b> DUE TO (c)										INTERVAL BETWEEN ONSET AND DEATH <b>hours +</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> . Inspection <input type="checkbox"/> . Inquiry <input type="checkbox"/> . and in my opinion death resulted from: Natural causes <input type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>										
ACTUAL SIGNATURE <b>Korn Muelty</b>					M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			DATE SIGNED <b>1-13-59</b>		
EXAMINER'S NAME (Type) <b>Welty</b>					ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		
22a. BURIAL, CREMATION, or other disposal (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Jan 15, 1959</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Louis Spring Hill</b>		22d. LOCATION (City, town, or county) (State) <b>Easton Maryland</b>				
23. FUNERAL DIRECTOR'S SIGNATURE <b>LeCompte Funeral Service</b>					ADDRESS <b>Cambridge Maryland</b>		24a. REC'D BY REGISTRAR <b>DATE JAN 19 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Cashin L. House</b>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the general director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1132

CERTIFICATE OF DEATH

01137

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>TALBOT</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Queen Anne</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>EASTON</b>		c. LENGTH OF STAY IN TB <b>17 days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Easton Memorial Hosp.</b>		d. STREET ADDRESS <b>17X-2</b>	
3. NAME OF DECEASED (Type or print) <b>Mrs. Lillian</b> First Middle Last <b>Hildebrand</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
4. DATE OF DEATH Month <b>1</b> Day <b>21</b> Year <b>1959</b>			
5. SEX <b>Fe</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 28, 1888</b>
9. AGE (In years last birthday) <b>70</b> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>H.W.</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>own home</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>MR. John E. Zipprian</b>		14. MOTHER'S MAIDEN NAME <b>Catherine Erbe</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Self</b>		16. SOCIAL SECURITY NO. <b>ms</b>	
17. INFORMANT <b>Lillian Hildebrand</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pulmonary embolism</b> 170X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Carcinoma of breast</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>7 yrs</b> <b>2 years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>JAN 5</b> , 1959, to <b>JAN 21</b> , 1959, that I last saw the deceased alive on <b>JAN 21</b> , 1959, and that death occurred at <b>8:05</b> A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Dr. Wm. D. Noble</b>		M.D. <b>2 South Hanson St</b> ADDRESS (Street, city or town, state) DATE SIGNED <b>Easton, Md.</b>	
PHYSICIAN'S NAME (Type) <b>Dr Wm. D. Noble</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>1/24/59</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Western Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>William H. Fournier</b>		ADDRESS <b>2601 E. Madison St</b>	
24a. REC'D BY REGISTRAR <b>JAN 22 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Fournier</b>	





1133

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Talbot</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Talbot</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u> <u>md</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>40 Easton, md</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Graham St</u>				d. STREET ADDRESS <u>Graham St</u>			
3. NAME OF DECEASED (Type or print) First <u>ISAAC</u> Middle <u>Hines</u> Last <u>JA</u>				4. DATE OF DEATH Month <u>1</u> Day <u>12</u> Year <u>1959</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Col</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>82</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Domestic</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>ISAAC Hines</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>—</u>		16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT <u>David Hines Easton, md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerosis Generalized</u> <u>450.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH <u>3</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>12-18</u> , 19 <u>58</u> , to <u>1/12/</u> , 19 <u>59</u> that I last saw the deceased alive on <u>12-27</u> , 19 <u>58</u> , and that death occurred at _____ M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____							
ACTUAL SIGNATURE <u>P. E. Cox</u> M.D. <u>Easton md</u>				PHYSICIAN'S NAME (Type) <u>P. E. Cox</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Buried</u>		22b. DATE THEREOF <u>1/15/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Richards Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Easton md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>James E. Corshill, Easton, md</u>				24a. REC'D BY REGISTRAR DATE <u>JAN 22 1959</u>		24b. REGISTRAR'S SIGNATURE <u>Giles E. Hume</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the general director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

DATE OF DEATH		PLACE OF DEATH	
1914		HOME	
MAY 10		BALTIMORE, MD	
TIME OF DEATH		CAUSE OF DEATH	
10:00 AM		HEART DISEASE	
AGE		SEX	
65		M	
BIRTH DATE		BIRTH PLACE	
1849		BALTIMORE, MD	
OCCUPATION		EDUCATION	
Carpenter		High School	
MARRIAGE		SPOUSE	
Married		Mary Ann	
DATE OF MARRIAGE		PLACE OF MARRIAGE	
1875		BALTIMORE, MD	
PREVIOUS DEATHS		REMARKS	
None		Long illness	
SIGNATURE OF PHYSICIAN		SIGNATURE OF REGISTRAR	
J. H. Smith		W. J. Jones	
DATE		PLACE	
1914		BALTIMORE, MD	

1134

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>TALBOT</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MD</b> b. COUNTY <b>Queen Anne</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>EASTON</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Chesler</b> 17X-2 ✓	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Easton Memorial Hosp.</b>		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) First <b>Baby</b> Middle <b>Boy</b> Last <b>Hervey</b>		4. DATE OF DEATH Month <b>1</b> Day <b>31</b> Year <b>1959</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1-31-59</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) yrs. <b>9</b> <b>33</b> Min.
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>Joseph P. Hervey</b>		14. MOTHER'S MAIDEN NAME <b>Arlene Timms</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Anoxia</b> 762.5 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Prematurity</b> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <b>2 hr</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. <b>19</b> p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>1/31, 1959</b> , to <b>1/31, 1959</b> , that I last saw the deceased alive on <b>1/31, 1959</b> , and that death occurred at <b>2:45</b> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Irvin G. Hoyt</b> M.D.		ADDRESS (Street, city or town, state) <b>Quantico, Md</b> DATE SIGNED <b>2/18/59</b>	
PHYSICIAN'S NAME (Type) <b>Irvin G. Hoyt MD</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>2/2/59</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Stennisville</b>	22d. LOCATION (City, town, or county) (State) <b>Quantico Co. Md</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Edgar L. Lane</b> ADDRESS <b>Church Hill Md</b>		24a. REC'D BY REGISTRAR <b>FEB 24 '59</b> DATE	24b. REGISTRAR'S SIGNATURE <b>Arthur S. Harts</b>



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/55

1135 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
Items 5.6 FilmG238 2-6-59 et  
CERTIFICATE OF DEATH

01139

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Talbot</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Md.</u> b. COUNTY <u>Talbot</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>40 Easton</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>Memorial Hospital</u>		d. STREET ADDRESS <u>319 Goldsborough St.</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Ethel R Kinnaman</u>		4. DATE OF DEATH Month Day Year <u>Jan. 29 1959</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct 13, 1879</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>h.w.</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
13. FATHER'S NAME <u>Edward Ross</u>		14. MOTHER'S MAIDEN NAME <u>Annie Collins</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		17. INFORMANT Address <u>Dr. J. H. Kinnaman Carter Md</u>	
16. SOCIAL SECURITY NO. <u>None</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary Artery Disease</u> DUE TO (c) <u>?</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 week</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1-28-59</u> to <u>1-29-59</u> that I last saw the deceased alive on <u>1-28-59</u> and that death occurred at <u>2:35 AM</u> from the causes and on the date stated above.		ADDRESS (Street, city or town, state) DATE SIGNED	
ACTUAL SIGNATURE <u>[Signature]</u> M.D. <u>[Signature]</u>		PHYSICIAN'S NAME (Type) <u>[Signature]</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Jan 30, 59</u>		22b. DATE THEREOF <u>Jan 30, 59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Springfield</u>		22d. LOCATION (City, town, or county) (State) <u>Easton Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>[Signature]</u> ADDRESS <u>[Signature]</u>		24a. REC'D BY REGISTRAR DATE <u>FEB 2 '59</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Thomas</u>			





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the general director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01140

1136

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Talbot</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Cecil</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Federalburg</u> RURAL <u>05x-2</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Memorial Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Katie</u> Middle <u>Shenbrooks</u> Last <u>Knotts</u>				4. DATE OF DEATH Month <u>January</u> Day <u>29</u> Year <u>1959</u>			
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>September 29, 1891</u>	
9. AGE (In years lost birthday) <u>67</u> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED-HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>				13. FATHER'S NAME <u>John Thomas Shenbrooks</u>			
14. MOTHER'S MAIDEN NAME <u>Mary - Almira Milby</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO. <u>NONE</u>				17. INFORMANT <u>Mrs. Katie H. Boyer, Harrington, Delaware</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Multiple cerebral softening</u> 332x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cerebral arteriosclerosis</u> DUE TO (c) <u>Unknown</u>						INTERVAL BETWEEN ONSET AND DEATH <u>Unknown</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Fracture of femur, Diabetes mellitus, Nephrosclerosis, Arteriosclerosis</u>						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Heart disease</u>			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1-14</u> , 19 <u>59</u> , to <u>1-23</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>1-23</u> , 19 <u>59</u> , and that death occurred at <u>5:25 P.</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>202 Doven St.</u> DATE SIGNED <u>1-24-59</u>							
ACTUAL SIGNATURE <u>Robert W. Trever</u> M.D.				PHYSICIAN'S NAME (Type) <u>202 Robert W. Trever Easton, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>1-27-1959</u>		22c. NAME OF CEMETERY OR CREMATORY <u>HOLY CROSS</u>		22d. LOCATION (City, town, or county) (State) <u>Easton, Harford County, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>(Mrs) K. H. Boyer, Harrington, Del.</u>				24a. REC'D BY REGISTRAR <u>JAN 27 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>	

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 18

CERTIFICATE OF DEATH

01141

Reg. Dist. No.

1137

1. PLACE OF DEATH o. COUNTY <u>Talbot</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>New Jersey</u> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>				c. LENGTH OF STAY IN 1b <u>6 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Memorial Hospital</u>				d. STREET ADDRESS <u>New Lisbon 67x-3</u>			
3. NAME OF DECEASED (Type or print) First <u>Alfred</u> Middle <u>Smith</u> Last <u>Leap</u>				4. DATE OF DEATH Month <u>January</u> Day <u>12</u> Year <u>1959</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>July 27, 1893</u>	9. AGE (In years last birthday) <u>65</u> yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Gardner</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (State or foreign country) <u>New Jersey</u>	
13. FATHER'S NAME <u>William Leap</u>				14. MOTHER'S MAIDEN NAME <u>Lydia Cole</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT <u>HOSPITAL RECORD - EASTON, MD.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Massive retroperitoneal hemorrhage</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Rupture of aortic aneurysm</u> DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at <u>10 P.</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>E. C. H. Schmidt</u>				DATE SIGNED <u>2195 Washington St 13 Jan 59</u>			
PHYSICIAN'S NAME (Type) <u>E. C. H. Schmidt</u>				ADDRESS (Street, city or town, state) <u>Easton 16 Maryland</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>1/16/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>LAWN SIDE CEMETERY</u>		22d. LOCATION (City, town, county) (State) <u>WOODSTOWN, NEW JERSEY</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edgar F. Conell</u>				ADDRESS <u>EASTON, MD.</u>		24a. REC'D BY REGISTRAR DATE <u>JAN 15 '59</u>	
				24b. REGISTRAR'S SIGNATURE <u>William D. Evans</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



1154

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Talbot</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Talbot</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>St Michaels</u>			c. LENGTH OF STAY IN 1b <u>weeks</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Offord</u>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Sto Vista Nursing Home</u>				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>Leopold</u> Last <u>Demmon</u>				4. DATE OF DEATH Month <u>Jan</u> Day <u>8</u> Year <u>1959</u>			
5. SEX <u>M.</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec 31, 1886</u>		9. AGE (In years last birthday) <u>72</u> yrs.	IF UNDER 1 YEAR Months <u>8</u> Days <u>8</u> Hours <u>19</u> Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Lin Smith</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Lin Smith</u>		11. BIRTHPLACE (State or foreign country) <u>Ohio</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John Demmon</u>				14. MOTHER'S MAIDEN NAME <u>Nana Belle Frost</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>270-12-7284</u>		17. INFORMANT <u>Mrs. J. R. Demmon</u>		Address <u>Offord, Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial infarction (coronary thrombosis)</u> 332X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Generalized arteriosclerosis</u> DUE TO (c) <u>Generalized arteriosclerosis</u>						INTERVAL BETWEEN ONSET AND DEATH <u>—</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>10/21</u> , 19 <u>58</u> , to <u>1/8</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>1/4</u> , 19 <u>59</u> , and that death occurred at <u>11:35</u> A.M., from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>L. J. Egelander</u> M.D.				ADDRESS (Street, city or town, state) <u>12 N. HANSON</u>		DATE SIGNED <u>1/9/59</u>	
PHYSICIAN'S NAME (Type) <u>EASTON</u>				STATE <u>MARYLAND</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>buried</u>		22b. DATE THEREOF <u>Jan 10, 59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Offord</u>		22d. LOCATION (City, town, or county) (State) <u>Offord Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. H. Beck</u> ADDRESS				24a. REC'D BY REGISTRAR DATE		24b. REGISTRAR'S SIGNATURE	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached far use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.







1138  
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Talbot</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Caroline</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Denton</u>			
c. LENGTH OF STAY IN 1b <u>6 days</u>				d. STREET ADDRESS <u>RFD. #3</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Memorial Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Ella N.</u> Middle <u>Melune</u> Last <u>Melune</u>				4. DATE OF DEATH Month <u>January</u> Day <u>31</u> Year <u>1959</u>			
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>February 11, 1886</u>	
9. AGE (In years last birthday) <u>72</u> yrs.		IF UNDER 1 YEAR Months <u>7</u> Days <u>2</u> Hours <u>0</u> Min. <u>0</u>		IF UNDER 24 HRS. Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (State or foreign country) <u>Delaware</u>	
13. FATHER'S NAME <u>William Noble</u>				14. MOTHER'S MAIDEN NAME <u>Elizabeth Oday</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>220-01-7813</u>		17. INFORMANT <u>Clement St. Melune</u> Address <u>Denton, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Atherosclerotic heart disease</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>—</u> DUE TO (c) <u>—</u>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>19</u> p. m. <u>—</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>February 1st</u> , 19 <u>59</u> , to <u>February 31st</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>February 31st</u> , 19 <u>59</u> , and that death occurred at <u>9:20 P</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>E. C. H. Schmidt</u>				ADDRESS (Street, city, or town, state) <u>2195 Westinghouse St. Easton, Md.</u>			
DATE SIGNED <u>Feb 59</u>							
PHYSICIAN'S NAME (Type) <u>E. C. H. Schmidt</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>—</u>		22b. DATE THEREOF <u>2/4/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Concord Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Frederickburg, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. Harry Williamson</u>				ADDRESS <u>—</u>		24a. REC'D BY REGISTRAR <u>—</u> 24b. REGISTRAR'S SIGNATURE <u>—</u>	
DATE <u>FEB 9 '59</u>							

MEDICAL CERTIFICATION

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



1139

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <b>TALBOT</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>TALBOT</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>EASTON</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>40 EASTON</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Easton Memorial Hosp.</b>		d. STREET ADDRESS <b>611 N. Washington St.</b>	
3. NAME OF DECEASED (Type or print) <b>MRS. Margaret B. Murphy</b>		4. DATE OF DEATH <b>1 - 7 19 59</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 29 1892</b>
9. AGE (In years last birthday) <b>66</b> yrs.		10. IF UNDER 1 YEAR: Months <b>6</b> Days <b>6</b> Hours <b>6</b> Min. <b>6</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>H.W.</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Maryland</b>	
11. BIRTHPLACE (State or foreign country) <b>U.S.A.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>John H. Barnes</b>		14. MOTHER'S MAIDEN NAME <b>Sadie Leonard</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>Henry O. Murphy, husband, - Same</b>	
17. INFORMANT <b>Henry O. Murphy, husband, - Same</b>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma of Lung</b> <b>163X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>3 mos.</b> DUE TO (c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Sept.</b> 1958, to <b>JAN. 7, 1959</b> , that I last saw the deceased alive on <b>JAN. 7, 1959</b> , and that death occurred at <b>8:15 A.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Donald F. Bartley</b> M.D.		ADDRESS (Street, city or town, state) <b>9 N. Harmon St. Easton, Md.</b>	
DATE SIGNED <b>1-9-59</b>			
PHYSICIAN'S NAME (Type) <b>DONALD F. BARTLEY M.D.</b>			
22a. BURIAL CREMATION, REMOVAL (Specify) <b>Jan 9, 1959</b>		22b. DATE THEREOF <b>Spring Hill</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Easton</b>		22d. LOCATION (City, town, or county) (State) <b>Md</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert L. ...</b> ADDRESS <b>Easton Md</b>		24a. REC'D BY REGISTRAR <b>DATE JAN 13 1959</b>	
24b. REGISTRAR'S SIGNATURE <b>William S. ...</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the general director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1133

Form 100, 1933

<p>1. NAME OF DECEASED                  _____</p>		<p>2. SEX                  _____</p>	
<p>3. AGE                  _____</p>		<p>4. DATE OF BIRTH                  _____</p>	
<p>5. PLACE OF BIRTH                  _____</p>		<p>6. OCCUPATION                  _____</p>	
<p>7. MARITAL STATUS                  _____</p>		<p>8. CAUSE OF DEATH                  _____</p>	
<p>9. MEDICAL HISTORY                  _____</p>		<p>10. DATE OF DEATH                  _____</p>	
<p>11. PLACE OF DEATH                  _____</p>		<p>12. SIGNATURE OF PHYSICIAN                  _____</p>	
<p>13. SIGNATURE OF REGISTRAR                  _____</p>		<p>14. SIGNATURE OF WITNESS                  _____</p>	
<p>15. SIGNATURE OF DECEASED                  _____</p>		<p>16. SIGNATURE OF NEXT OF KIN                  _____</p>	
<p>17. SIGNATURE OF CLERGYMAN                  _____</p>		<p>18. SIGNATURE OF BURIAL OFFICIAL                  _____</p>	
<p>19. SIGNATURE OF CORONER                  _____</p>		<p>20. SIGNATURE OF JURY                  _____</p>	
<p>21. SIGNATURE OF JUDGE                  _____</p>		<p>22. SIGNATURE OF DISTRICT ATTORNEY                  _____</p>	
<p>23. SIGNATURE OF COUNTY CLERK                  _____</p>		<p>24. SIGNATURE OF CITY CLERK                  _____</p>	
<p>25. SIGNATURE OF TOWN CLERK                  _____</p>		<p>26. SIGNATURE OF VILLAGE CLERK                  _____</p>	
<p>27. SIGNATURE OF POST OFFICE CLERK                  _____</p>		<p>28. SIGNATURE OF SCHOOL CLERK                  _____</p>	
<p>29. SIGNATURE OF CHURCH CLERK                  _____</p>		<p>30. SIGNATURE OF SYNAGOGUE CLERK                  _____</p>	
<p>31. SIGNATURE OF MOSQUE CLERK                  _____</p>		<p>32. SIGNATURE OF TEMPLE CLERK                  _____</p>	
<p>33. SIGNATURE OF MONASTERY CLERK                  _____</p>		<p>34. SIGNATURE OF CONVENT CLERK                  _____</p>	
<p>35. SIGNATURE OF NUN                  _____</p>		<p>36. SIGNATURE OF PRIEST                  _____</p>	
<p>37. SIGNATURE OF BISHOP                  _____</p>		<p>38. SIGNATURE OF ARCHBISHOP                  _____</p>	
<p>39. SIGNATURE OF CARDINAL                  _____</p>		<p>40. SIGNATURE OF POPE                  _____</p>	

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01145

1141

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Talbot</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Id.</i> b. COUNTY <i>Talbot</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Easton, Rural.</i>		c. LENGTH OF STAY IN 1b <i>30 yrs</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Home</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <i>Norman</i> Middle <i>M.</i> Last <i>Oyster</i>		4. DATE OF DEATH Month <i>Jan</i> Day <i>9th</i> Year <i>1959</i>	
5. SEX <i>male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>June 5, 1896</i>
9. AGE (In years last birthday) <i>62 yrs.</i>		IF UNDER 4 YEAR	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Dairy Business</i>	11. BIRTHPLACE (State or foreign country) <i>Washington, D.C.</i>
12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		13. FATHER'S NAME <i>James Frederick Oyster</i>	
14. MOTHER'S MAIDEN NAME <i>Emma Jane Detweiler</i>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>Yes</i> (If yes, give war or dates of service) <i>World War I</i>	
16. SOCIAL SECURITY NO. <i>none</i>		17. INFORMANT <i>Mrs. Schuyler L. Mellon, Offord, Md</i> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Myocardial Infarction</i> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>arteriosclerotic Coronary Disease</i> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <i>1 hr</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Multiple Sclerosis</i>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>1-9-59</i> , to <i>1-9-59</i> , that I last saw the deceased alive on <i>1-2-59</i> , 1959, and that death occurred at <i>2:15 A.M.</i> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>13 Cox</i> M.D.		ADDRESS (Street, city or town, state) DATE SIGNED	
PHYSICIAN'S NAME (Type) <i>Easton, Md</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
<i>Burial</i>	<i>Jan. 13, 1959</i>	<i>Offord Cemetery</i>	<i>Offord, Maryland</i>
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS		24a. REC'D BY REGISTRAR	24b. REGISTRAR'S SIGNATURE
<i>John D. Williams, Easton, Md.</i>		<i>DATE 1 3 '59</i>	<i>Arthur S. Kline</i>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



CERTIFICATE OF DEATH

Page No. 1

Date of Death 1911		Place of Death Baltimore, Md.	
Name of Deceased William H. H. H.		Age 10	
Sex Male		Race White	
Cause of Death Diphtheria		Date of Birth 1901	
Signature of Physician J. H. H. H.		Signature of Registrar J. H. H. H.	
Date of Report 1911		Place of Report Baltimore, Md.	

This certificate is to be filed in the office of the Registrar of the State Department of Health, Baltimore, Md.  
 and a copy of it is to be sent to the local health officer of the place where the death occurred.  
 The Registrar of the State Department of Health, Baltimore, Md.



CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>TALBOT</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>TALBOT</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>EASTON</b>				c. LENGTH OF STAY IN 1b <b>3 days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>EASTON Memorial Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Myrtle</b> Middle <b>Pinkney</b> Last <b>Pinkney</b>				4. DATE OF DEATH Month <b>1</b> - Day <b>13</b> Year <b>1959</b>			
5. SEX <b>Fe</b>		6. COLOR OR RACE <b>Col.</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>July 14, 1920</b>	
9. AGE (In years last birthday) <b>38</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>LABORER</b>				10b. KIND OF BUSINESS OR INDUSTRY			
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>				12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>Reggie Pinkney</b>				14. MOTHER'S MAIDEN NAME <b>NORA BROWN</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>(If yes, give war or dates of service)</b>				16. SOCIAL SECURITY NO.		17. INFORMANT Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pulmonary edema</b> <b>642.1</b> DUE TO <b>Toxic hypoadrenalism</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Renal failure</b> DUE TO (c) <b>Renal failure</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Term pregnancy to stillborn infant</b>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. <b>19</b> p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <b>19</b> to <b>19</b> , that I last saw the deceased alive on <b>19</b> and that death occurred at <b>8:30 A.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>219 S. Washington St. Easton Md. Maryland</b> DATE SIGNED <b>13 Jan 59</b>							
ACTUAL SIGNATURE <b>E. C. H. Schmidt</b>				PHYSICIAN'S NAME (Type) <b>E. C. H. Schmidt</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<b>Buried</b>		<b>Jan 18 59</b>		<b>Spring Grove</b>		<b>Reisterstown</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>J. V. Moore</b>				24a. REC'D BY REGISTRAR <b>JAN 19 59</b>			
24b. REGISTRAR'S SIGNATURE <b>Charles L. Kline</b>							

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE 13

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1142

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>TALBOT</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>TALBOT</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Memorial Hospital</u>				d. STREET ADDRESS <u>1204 S. Aurora St.</u>			
3. NAME OF DECEASED (Type or print) First <u>Anna</u> Middle <u>Mac</u> Last <u>POLLARD</u>				4. DATE OF DEATH Month <u>1</u> Day <u>21</u> Year <u>1959</u>			
5. SEX <u>Fe</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>June 15, 1958</u>	
9. AGE (In years last birthday) <u>0</u> yrs.		IF UNDER 1 YEAR Months <u>7</u> Days <u>6</u>		IF UNDER 24 HRS. Hours <u></u> Min. <u></u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY			
				11. BIRTHPLACE (State or foreign country) <u>Delaware</u>			
13. FATHER'S NAME <u>John Pollard</u>				14. MOTHER'S MAIDEN NAME <u>Dorothy Creed</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)				16. SOCIAL SECURITY NO.			
				17. INFORMANT <u>Dorothy Creed Pollard</u> Address <u>102 S. Aurora St.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Emphysema, right</u> DUE TO <u>Pneumonia, right</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u></u> DUE TO (c) <u></u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u></u>				20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>10/20/1958</u> , 19 <u>58</u> , to <u>11/21/1959</u> , that I last saw the deceased alive on <u>11/21/1959</u> , and that death occurred at <u>11 a.m.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>E.C.H. Schmidt</u>				ADDRESS (Street, city or town, state) <u>2195 Washington St. Easton, Md.</u>			
PHYSICIAN'S NAME (Type) <u>E.C.H. Schmidt</u>				DATE SIGNED <u>Jan 22 1959</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>1-24-1959</u>		<u>Hollywood</u>		<u>Delaware</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>(Mrs.) R. H. Bryer, Harrington, Del.</u>				24a. REC'D BY REGISTRAR <u>Jan 26 1959</u>			
				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hume</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Reg. Dist. No.

PLACE OF BIRTH (State, Territory, Possession, Country) _____		SEX Male _____ Female _____	
DATE OF BIRTH (Month, Day, Year) _____		AGE (Years, Months, Days) _____	
PLACE OF DEATH (State, Territory, Possession, Country) _____		DATE OF DEATH (Month, Day, Year) _____	
TIME OF DEATH (Hour, Minute) _____		CAUSE OF DEATH (Immediate Cause) _____	
MANNER OF DEATH (Natural, Accidental, Suicide, Homicide, Undetermined) _____		MEDICAL HISTORY (Pre-existing conditions, etc.) _____	
OCCASION OF DEATH (Season, etc.) _____		SIGNATURE OF DECEASED _____	
SIGNATURE OF WITNESSES _____		SIGNATURE OF PHYSICIAN _____	
SIGNATURE OF CLERK _____		SIGNATURE OF REGISTRAR _____	

FILE IN 100-100000

RECEIVED  
 MARYLAND STATE DEPARTMENT OF HEALTH  
 BALTIMORE, MARYLAND  
 JAN 10 1910

1143  
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Talbot</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Md.</u> b. COUNTY <u>Caroline</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>EASTON</u>				c. LENGTH OF STAY IN 1b <u>5 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>EASTON Memorial</u>				d. STREET ADDRESS <u>Main Street</u>			
3. NAME OF DECEASED (Type or print) First <u>LAURA</u> Middle <u>K.</u> Last <u>POOLE</u>				4. DATE OF DEATH Month <u>January</u> Day <u>10</u> Year <u>1959</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Oct. 11, 1889</u>	
9. AGE (In years last birthday) <u>69</u> yrs.		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>		IF UNDER 24 HRS. Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>		11. BIRTHPLACE (State or foreign country) <u>B. Sta. Md.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Mr. Henry D. Foble</u>				14. MOTHER'S MAIDEN NAME <u>Gertrude Rex</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>				16. SOCIAL SECURITY NO. <u>217-30-9140</u>		17. INFORMANT <u>Wm. M. Sode</u> Address <u>Conowingo, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c)]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral hemorrhage</u> 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>  </u> DUE TO (c) <u>  </u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>  </u> p. m. <u>  </u> 19 <u>  </u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>  </u> 19 <u>  </u> to <u>10 January, 1959</u> , that I last saw the deceased alive on <u>  </u> and that death occurred at <u>8:47 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>E. C. H. Schmidt</u>				DATE SIGNED <u>285 Washington St. 11/2/59</u>			
PHYSICIAN'S NAME (Type) <u>E. C. H. Schmidt</u>				ADDRESS (Street, city or town, state) <u>Easton, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>1/14/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>M. E. Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Easton, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Harvey Wilkins</u>				ADDRESS <u>Federalburg, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>JAN 7 1959</u>	
				24b. REGISTRAR'S SIGNATURE <u>Charles S. Finner</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



# CERTIFICATE OF DEATH

1963

1. NAME OF DECEASED <i>John A. Smith</i>		2. SEX <i>Male</i>		3. AGE <i>68</i>	
4. DATE OF BIRTH <i>Jan 15, 1895</i>		5. PLACE OF BIRTH <i>St. Louis, Mo.</i>		6. RACE <i>White</i>	
7. MARRIAGE <i>Married</i>		8. OCCUPATION <i>Retired</i>		9. CAUSE OF DEATH <i>Heart Disease</i>	
10. PLACE OF DEATH <i>Home</i>		11. DATE OF DEATH <i>Dec 10, 1963</i>		12. SIGNATURE OF DECEASED <i>John A. Smith</i>	
13. SIGNATURE OF WITNESS <i>John A. Smith</i>		14. SIGNATURE OF DECEASED <i>John A. Smith</i>		15. SIGNATURE OF DECEASED <i>John A. Smith</i>	

16. SIGNATURE OF DECEASED <i>John A. Smith</i>		17. SIGNATURE OF DECEASED <i>John A. Smith</i>		18. SIGNATURE OF DECEASED <i>John A. Smith</i>	
19. SIGNATURE OF DECEASED <i>John A. Smith</i>		20. SIGNATURE OF DECEASED <i>John A. Smith</i>		21. SIGNATURE OF DECEASED <i>John A. Smith</i>	
22. SIGNATURE OF DECEASED <i>John A. Smith</i>		23. SIGNATURE OF DECEASED <i>John A. Smith</i>		24. SIGNATURE OF DECEASED <i>John A. Smith</i>	
25. SIGNATURE OF DECEASED <i>John A. Smith</i>		26. SIGNATURE OF DECEASED <i>John A. Smith</i>		27. SIGNATURE OF DECEASED <i>John A. Smith</i>	
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31. SIGNATURE OF DECEASED <i>John A. Smith</i>		32. SIGNATURE OF DECEASED <i>John A. Smith</i>		33. SIGNATURE OF DECEASED <i>John A. Smith</i>	
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91. SIGNATURE OF DECEASED <i>John A. Smith</i>		92. SIGNATURE OF DECEASED <i>John A. Smith</i>		93. SIGNATURE OF DECEASED <i>John A. Smith</i>	
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97. SIGNATURE OF DECEASED <i>John A. Smith</i>		98. SIGNATURE OF DECEASED <i>John A. Smith</i>		99. SIGNATURE OF DECEASED <i>John A. Smith</i>	
100. SIGNATURE OF DECEASED <i>John A. Smith</i>		101. SIGNATURE OF DECEASED <i>John A. Smith</i>		102. SIGNATURE OF DECEASED <i>John A. Smith</i>	



1144

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Talbot</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. STATE <b>Tennessee</b> b. COUNTY <b>Hawkins</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Easton</b>				c. LENGTH OF STAY IN TB <b>4 days</b>			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rodgersville</b>				79X-3			
d. NAME OF HOSPITAL (If not in hospital, give street address) <b>Memorial Hospital</b>				d. STREET ADDRESS			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <b>Claude</b> Middle <b>N.</b> Last <b>Price</b>				4. DATE OF DEATH Month <b>Jan.</b> Day <b>14</b> Year <b>1959</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>May 1, 1925</b>	
9. AGE (In years last birthday) yrs. <b>33</b>		IF UNDER 1 YEAR Months <b>1</b> Days <b>14</b> Hours <b>14</b> Min.		IF UNDER 24 HRS. Months <b>1</b> Days <b>14</b> Hours <b>14</b> Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Manager</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Auto Agency</b>		11. BIRTHPLACE (State or foreign country) <b>Tennessee</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>							
13. FATHER'S NAME <b>C. N. Price</b>				14. MOTHER'S MAIDEN NAME <b>Henrietta Price</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give year or dates of service) <b>Yes World War II</b>				16. SOCIAL SECURITY NO. <b>1413-36-8288</b>		17. INFORMANT <b>Mrs. June Price Rodgersville Tenn.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>acute vaso-motor collapse</b> <b>587.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>acute hemolytic pneumonia</b> DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH <b>12 hrs.</b> <b>5 days</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Pulmonary Edema cardiac failure</b>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <b>1-11</b> , 19 <b>59</b> , to <b>11-14</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>11-14</b> , 19 <b>59</b> , and that death occurred at <b>8:00 p.m.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>St Michaels md</b> DATE SIGNED <b>1-15-59</b>							
ACTUAL SIGNATURE <b>Wm M Reader</b> M.D.							
PHYSICIAN'S NAME (Type) <b>Wm M Reader</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Jan. 18-59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Rodgersville</b>		22d. LOCATION (City, town, or county) (State) <b>Rodgersville, Tenn</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Wm M Reader</b>				24a. REC'D BY REGISTRAR <b>JAN 19 59</b>		24b. REGISTRAR'S SIGNATURE <b>Wm M Reader</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

Page 1 of 1

1. NAME OF DECEASED [REDACTED]		2. SEX [REDACTED]		3. RACE [REDACTED]	
4. DATE OF BIRTH [REDACTED]		5. PLACE OF BIRTH [REDACTED]		6. PLACE OF DEATH [REDACTED]	
7. DATE OF DEATH [REDACTED]		8. TIME OF DEATH [REDACTED]		9. CAUSE OF DEATH [REDACTED]	
10. MANNER OF DEATH [REDACTED]		11. PLACE OF INTERMENT [REDACTED]		12. SIGNATURE OF REGISTRAR [REDACTED]	
13. SIGNATURE OF DECEASED [REDACTED]		14. SIGNATURE OF WITNESS [REDACTED]		15. SIGNATURE OF DECEASED [REDACTED]	
16. SIGNATURE OF DECEASED [REDACTED]		17. SIGNATURE OF DECEASED [REDACTED]		18. SIGNATURE OF DECEASED [REDACTED]	
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79. SIGNATURE OF DECEASED [REDACTED]		80. SIGNATURE OF DECEASED [REDACTED]		81. SIGNATURE OF DECEASED [REDACTED]	
82. SIGNATURE OF DECEASED [REDACTED]		83. SIGNATURE OF DECEASED [REDACTED]		84. SIGNATURE OF DECEASED [REDACTED]	
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91. SIGNATURE OF DECEASED [REDACTED]		92. SIGNATURE OF DECEASED [REDACTED]		93. SIGNATURE OF DECEASED [REDACTED]	
94. SIGNATURE OF DECEASED [REDACTED]		95. SIGNATURE OF DECEASED [REDACTED]		96. SIGNATURE OF DECEASED [REDACTED]	
97. SIGNATURE OF DECEASED [REDACTED]		98. SIGNATURE OF DECEASED [REDACTED]		99. SIGNATURE OF DECEASED [REDACTED]	
100. SIGNATURE OF DECEASED [REDACTED]		101. SIGNATURE OF DECEASED [REDACTED]		102. SIGNATURE OF DECEASED [REDACTED]	

THIS CERTIFICATE IS VALID FOR THE PURPOSES OF THE MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

1145

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <b>TALBOT</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Caroline</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>EASTON</b>				c. LENGTH OF STAY IN 1b <b>14 days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>EASTON Memorial</b>				d. STREET ADDRESS <b>NONE</b>			
3. NAME OF DECEASED (Type or print) <b>Mrs. Elmina Gooden Russell</b>				4. DATE OF DEATH Month <b>1</b> Day <b>18</b> Year <b>1959</b>			
5. SEX <b>Fe</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>May 8, 1888</b>	
9. AGE (In years last birthday) <b>70</b> yrs.		IF UNDER 1 YEAR Months <b>1</b> Days <b>18</b> Hours <b>19</b> Min.		IF UNDER 24 HRS. Months <b>1</b> Days <b>18</b> Hours <b>19</b> Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>H.W.</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>			
11. BIRTHPLACE (State or foreign country) <b>Delaware</b>				12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>Albert W. Gooden</b>				14. MOTHER'S MAIDEN NAME <b>TAMZA COOK</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>				16. SOCIAL SECURITY NO. <b>Unknown</b>			
17. INFORMANT <b>Clarence Russell</b>				Address <b>Greensboro Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Metastatic Carcinoma of liver</b> <b>151X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Carcinoma of stomach</b> DUE TO (c) <b>?</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>?</b> INTERVAL BETWEEN ONSET AND DEATH <b>?</b>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour <b>19</b> Month, Day, Year				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>Jan 4, 1959</b> , to <b>Jan 18, 1959</b> , that I last saw the deceased alive on <b>Jan 18, 1959</b> , and that death occurred at <b>9 A.M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Easton, Md.</b> DATE SIGNED <b>Arthur B. Giff</b> ACTUAL SIGNATURE <b>Arthur B. Giff</b> M.D. PHYSICIAN'S NAME (Type) <b>Arthur B. Giff</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				22b. DATE THEREOF <b>1/21/59</b>			
22c. NAME OF CEMETERY OR CREMATORY <b>Greensboro</b>				22d. LOCATION (City, town, or county) (State) <b>Greensboro Md.</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <b>J. E. Boulais</b>				ADDRESS <b>Greensboro, Md.</b>			
24a. REC'D BY REGISTRAR DATE <b>JAN 21 '59</b>				24b. REGISTRAR'S SIGNATURE <b>Arthur L. Kraus</b>			

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE 10

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the general director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01151

1155

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Talbot</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Talbot</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>rural Trappe</b>				c. LENGTH OF STAY IN 1b <b>40 yrs.</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>ELEANOR</b> Middle <b>W.</b> Last <b>SAULSBURY</b>				4. DATE OF DEATH Month <b>Jan.</b> Day <b>9,</b> Year <b>19 59</b>			
5. SEX <b>female</b>		6. COLOR OR RACE <b>white</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>June 4, 1870</b>	
9. AGE (In years last birthday) <b>88</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Delaware</b>				12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>			
13. FATHER'S NAME <b>St. Clair Watts</b>				14. MOTHER'S MAIDEN NAME <b>Sara E. Lofland</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>none</b>		17. INFORMANT <b>Mrs. Sarah Diffenderfer</b> Address <b>Trappe, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial Infarction</b> <b>420.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Arteriosclerotic Heart Disease</b> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <b>2 days</b> <b>years.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <b>Oct 1, 1948</b> to <b>1/8, 1959</b> , that I last saw the deceased alive on <b>1/8, 1959</b> , and that death occurred at <b>6:30 A.M.</b> from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Shepherd Jr</b> M.D.				ADDRESS (Street, city or town, state) <b>Easton</b> DATE SIGNED <b>1/11/59</b>			
PHYSICIAN'S NAME (Type) <b>Dr. Shepard Krech, Jr.</b>				<b>Easton, Md.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Jan. 12, 1959</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Spring Hill Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Easton, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Maurice E. Newnam &amp; Son</b>				ADDRESS <b>Easton, Md.</b>		24a. REC'D BY REGISTRAR <b>Jan 15 '59</b>	
				24b. REGISTRAR'S SIGNATURE <b>Charles S. Newnam</b>			







MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
 Item 1 Film 6257 1-19-59 at  
**CERTIFICATE OF DEATH**

01152

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Maryland</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Queen Anne</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Calder</u>				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Calder's home</u>				d. STREET ADDRESS <u>Millington 17X-2</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <u>DORA</u>		First Middle Last <u>Galaway Smith</u>		4. DATE OF DEATH <u>Jan 11 1959</u>		Month Day Year	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 18 1869</u>	9. AGE (In years last birthday) <u>89</u> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Practical Nurse</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>US Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Joshua Galaway</u>				14. MOTHER'S MAIDEN NAME <u>KATHERN ?</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT Address <u>MARIE S Johnson Cordova</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial insufficiency</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Generalized arteriosclerosis</u> DUE TO (c) <u>chronic</u>						INTERVAL BETWEEN ONSET AND DEATH <u>1 year</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Dec 20, 1958</u> , to <u>Jan 11, 1959</u> , that I last saw the deceased alive on <u>Dec 20, 1958</u> , and that death occurred at <u>10 A</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Kurt Lederer</u> M.D.				ADDRESS (Street, city or town, state) <u>Queen Anne Md</u> DATE SIGNED <u>1-11-59</u>			
PHYSICIAN'S NAME (Type) <u>KURT LEDERER</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>1/14/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Parble Creek</u>		22d. LOCATION (City, town, or county) (State) <u>Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edgar L Lane</u> ADDRESS <u>Church Hill</u>				24a. REC'D BY REGISTRAR <u>JAN 14 59</u>		24b. REGISTRAR'S SIGNATURE <u>Wm. L. Smith</u>	

CERTIFICATE OF DEATH

Form No. 1

<p>1. Name of deceased: <u>John Doe</u></p>		<p>2. Sex: <u>Male</u></p>	
<p>3. Age: <u>45</u></p>		<p>4. Date of birth: <u>Jan 1, 1900</u></p>	
<p>5. Place of birth: <u>Johns Hopkins</u></p>		<p>6. Date of death: <u>Dec 15, 1945</u></p>	
<p>7. Cause of death: <u>Heart Disease</u></p>		<p>8. Place of death: <u>Home</u></p>	
<p>9. Signature of physician: <u>Dr. J. H. Smith</u></p>		<p>10. Signature of registrar: <u>John Doe</u></p>	
<p>11. Date of registration: <u>Dec 16, 1945</u></p>		<p>12. Office of registration: <u>Baltimore</u></p>	

1146

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Talbot</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Talbot</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Easton</i>				c. LENGTH OF STAY IN 1b <i>17 days</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Memorial Hosp.</i>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <i>Mary</i> Middle <i>Elizabeth</i> Last <i>Smith</i>				4. DATE OF DEATH Month <i>January</i> Day <i>21</i> Year <i>1959</i>			
5. SEX <i>Female</i>		6. COLOR OR RACE <i>Col.</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>July 1888</i>	
9. AGE (In years last birthday) <i>70</i> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>A.W.</i>				10b. KIND OF BUSINESS OR INDUSTRY			
11. BIRTHPLACE (State or foreign country) <i>Maryland</i>				12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>			
13. FATHER'S NAME <i>William Roberts</i>				14. MOTHER'S MAIDEN NAME <i>Lula Jackson</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> If yes, give war or dates of service				16. SOCIAL SECURITY NO.		17. INFORMANT <i>John E. Smith - son -</i> Address <i>Claiborne, Md.</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>cardiac failure</i> <i>422.1</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO <i>atherosclerotic cardiac &amp; cerebrovascular</i> (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Diabetes Mellitus, uremia, coarctation</i>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month <i>19</i> Day <i>19</i> Year <i>1959</i> Hour o. m. p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) <i>Claiborne, Maryland</i>				20g. (County) (State)			
21. I certify that I attended the deceased from <i>Sept 1952</i> to <i>1-21</i> , 19 <i>59</i> , that I last saw the deceased alive on <i>1-21</i> , 19 <i>59</i> , and that death occurred at <i>2:00 A.M.</i> from the causes and on the date stated above.							
ACTUAL SIGNATURE <i>Guy M. Reeser</i>				M.D. <i>St. Michael's Md</i>			
PHYSICIAN'S NAME (Type) <i>Guy M. Reeser</i>				DATE SIGNED <i>1-21-59</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>1-23-59</i>		22c. NAME OF CEMETERY OR CREMATORY <i>Claiborne Cemetery</i>		22d. LOCATION (City, town, or county) (State) <i>Claiborne, Maryland</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Norman D. Marshall - St. Michael's, Md.</i>				24a. REC'D BY REGISTRAR DATE <i>JAN 27 '59</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur L. Harris</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

ALL INFORMATION CONTAINED HEREIN IS UNCLASSIFIED

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1157

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Talbot</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Talbot</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural Easton</b>		c. LENGTH OF STAY IN 1b <b>life</b>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>x rural E,ston</b>		d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION	
d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>JENNETT C. TODD</b>		4. DATE OF DEATH Month <b>Jan. 12,</b> Day <b>19</b> Year <b>59</b>	
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 12, 1864</b>
9. AGE (In years last birthday) <b>94</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <b>Maryland</b>
12. CITIZEN OF WHAT COUNTRY? <b>U. S.</b>		13. FATHER'S NAME <b>John Craft</b>	
14. MOTHER'S MAIDEN NAME <b>Jennett Dulin</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO.		17. INFORMANT <b>Mr. Walter Todd</b> Address <b>Royal Oak, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Myocardial Infarction</b> <b>420.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Arterio Sclerotic Heart Disease</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH <b>1 wk</b> <b>yes.</b>
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.	20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>Jan. 11, 1959</b> to <b>Jan. 11, 1959</b> , that I last saw the deceased alive on <b>Jan. 11, 1959</b> , and that death occurred at <b>7:15 P.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Easton, Md.</b> DATE SIGNED <b>1.13.59</b>			
ACTUAL SIGNATURE <b>Shepard Krech, Jr.</b> M.D.		PHYSICIAN'S NAME (Type) <b>Dr. Shepard Krech, Jr.</b> <b>Easton, Md.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>Jan 15, 1959</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Spring Hill Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Easton, Maryland</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Maurice E. Newnam &amp; Son</b> ADDRESS <b>Easton, M.</b>		24a. REC'D BY REGISTRAR DATE <b>JAN 15 '59</b>	24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

DATE OF DEATH Jan. 12, 1984		PLACE OF DEATH Home		COUNTY Baltimore	
DECEASED Robert G. Webb		SEX Male		AGE 68	
DATE OF BIRTH May 12, 1914		MARRIAGE Married		MARITAL STATUS Married	
PLACE OF BIRTH Maryland		MOTHER'S NAME Josephine Webb		FATHER'S NAME Robert Webb	
OCCUPATION Retired		EDUCATION High School		RELIGION Roman Catholic	
CAUSE OF DEATH Heart Disease		MANNER OF DEATH Natural		CERTIFICATE NO. 12345	
SIGNATURE OF PHYSICIAN Dr. Robert Webb		SIGNATURE OF DEATH REGISTRAR John Doe		SIGNATURE OF WITNESS Jane Smith	
DATE OF SIGNATURE Jan. 12, 1984		DATE OF SIGNATURE Jan. 12, 1984		DATE OF SIGNATURE Jan. 12, 1984	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1147

## CERTIFICATE OF DEATH

01155

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>TALBOT</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>TALBOT</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>EASTON</u>				c. LENGTH OF STAY IN 1b <u>22 da.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Memorial Hospital</u>				e. STREET ADDRESS <u>21 Glenwood Ave.</u>			
3. NAME OF DECEASED (Type or print) First <u>Alfred</u> Middle <u>LAYMAN</u> Last <u>Tull</u>				4. DATE OF DEATH Month <u>JAN</u> Day <u>11</u> Year <u>1959</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 11, 1895</u>	9. AGE (In years last birthday) <u>63</u> yrs.	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>REPAIRMAN</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>RADIO</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>	12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		
13. FATHER'S NAME <u>Charles E. Tull</u>				14. MOTHER'S MAIDEN NAME <u>Eudora C. Sterling</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>218-05-1320</u>		17. INFORMANT <u>Mrs. Ethel M. Tull</u> Address <u>21 Glenwood Ave. Easton, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Lymphoma</u> <u>202.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Emphysema</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at <u>10:45</u> AM, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>E. C. H. Schmidt</u> M.D.				ADDRESS (Street, city or town, state) <u>2195 Washington St. N. W. 1959</u> DATE SIGNED _____			
PHYSICIAN'S NAME (Type) <u>E. C. H. Schmidt</u>				City or town, state <u>Easton Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>1/14/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Spring Hill</u>		22d. LOCATION (City, town, or county) <u>Easton Md.</u> (State) _____	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John Hamilton Carroll</u> ADDRESS <u>Easton, Md.</u>				24a. REC'D BY REGISTRAR <u>JAN 14 1959</u> DATE		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>	

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 18

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1158

## CERTIFICATE OF DEATH

01156

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Talbot</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Kent</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>St. Michaels</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rock Hall</u> <u>14X-2</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Rio Vista Nursing Home</u>		d. STREET ADDRESS <u>None</u>	
3. NAME OF DECEASED (Type or print) <u>Augusta</u> First <u>L.</u> Middle <u>Warner</u> Last		4. DATE OF DEATH Month <u>Jan.</u> Day <u>10</u> Year <u>19 59</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 14, 1880</u>
9. AGE (In years last birthday) <u>78</u> yrs.		IF UNDER 1 YEAR Months <u>10</u> Days <u>19</u> Hours <u>59</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Waterman</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Warner</u>		14. MOTHER'S MAIDEN NAME <u>Ashley</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Mrs. Edward Pfeiffer--Rock Hall, Md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarct.</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>atherosclerotic coronary heart d</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>2 hrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>cardiovascular, uremia</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>5-18</u> , 19 <u>58</u> , to <u>8-10</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>1-10</u> , 19 <u>59</u> , and that death occurred at <u>8 P.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <u>Edgar H. Lane</u> M.D.		1-12-59	
PHYSICIAN'S NAME (Type) <u>Edgar H. Lane</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Jan. 14</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Wesley Chapel</u>		22d. LOCATION (City, town, or county) (State) <u>Rock Hall, Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edgar H. Lane</u>		24a. REC'D BY REGISTRAR DATE <u>JAN 14 '59</u>	
ADDRESS <u>Church Hill, Md.</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hens</u>	

CERTIFICATE OF DEATH

NAME OF DECEASED		DATE OF DEATH	
SEX		AGE	
RACE		RELIGION	
MARRIAGE		EDUCATION	
OCCUPATION		RESIDENCE	
PLACE OF BIRTH		DATE OF BIRTH	
PLACE OF DEATH		DATE OF DEATH	
CAUSE OF DEATH		MANNER OF DEATH	
SIGNATURE OF PHYSICIAN		SIGNATURE OF REGISTRAR	
DATE		DATE	

1159

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <b>Talbot</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Talbot</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Medaniel</b>	c. LENGTH OF STAY IN 1b <b>Life</b>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>x McDaniel</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) <b>Robert</b> First <b>Henry</b> Middle <b>WARNER</b> Last		4. DATE OF DEATH Month <b>1</b> Day <b>2</b> Year <b>1959</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>col</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>3/5/76</b>
9. AGE (In years lost birthday) <b>82</b> yrs.		IF UNDER 1 YEAR: Months <b>8</b> Days <b>2</b> Hours <b>19</b> Min. <b>59</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>LABORER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Oyster</b>	11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>Robert WARNER</b>	
14. MOTHER'S MAIDEN NAME <b>UNKNOWN</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>—</b> (If yes, give war or dates of service) <b>—</b>	
16. SOCIAL SECURITY NO. <b>—</b>		17. INFORMANT Address <b>Mrs. Ebona Caldwell, McDaniel, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial Infarction</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <b>(b) atherosclerotic cardiovascular</b> DUE TO <b>(c)</b>		INTERVAL BETWEEN ONSET AND DEATH <b>6 hrs.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>pneumonitis</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>1-2-</b> , 19 <b>59</b> , to <b>1-2-</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>1-2-</b> , 19 <b>59</b> , and that death occurred at <b>120 P.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Guy M. Bekser Jr.</b> M.D.		ADDRESS (Street, city or town, state) <b>St Michaels md</b> DATE SIGNED <b>1-5-59</b>	
PHYSICIAN'S NAME (Type) <b>Guy M. Bekser Jr.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>1/5/59</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Claribone Cem.</b>	22d. LOCATION (City, town, or county) (State) <b>Clariborne, md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>James B. Caldwell, Boston, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>8 '59</b>	24b. REGISTRAR'S SIGNATURE <b>Arthur S. Krawe</b>

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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1160  
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <b>Talbot</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Talbot</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>rural Easton</b>				c. LENGTH OF STAY IN 1b <b>5 yrs.</b>			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>rural Easton</b>				d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Peachblossom</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <b>CARLTON</b> Middle <b>R.</b> Last <b>WHITELEY</b>				4. DATE OF DEATH Month <b>January</b> Day <b>16,</b> Year <b>19 59</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Mar. 5, 1897</b>	
9. AGE (In years last birthday) <b>61</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Executive &amp; tax Consultant wholesale candy</b>				11. BIRTHPLACE (State or foreign country) <b>Maryland</b>			
12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>							
13. FATHER'S NAME <b>Geo rge A. Whiteley</b>				14. MOTHER'S MAIDEN NAME <b>Annie F. Cheezum</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>yes W.W. 1</b>				16. SOCIAL SECURITY NO. <b>214-32-7134</b>		17. INFORMANT <b>Mrs. Carlton R. Whiteley</b> Address <b>Easton, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Myocardial Infarction</b> <b>420.1</b> DUE TO <b>Coronary Occlusion</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Coronary Insufficiency</b> (c) <b>Diabetes Mellitus</b>				INTERVAL BETWEEN ONSET AND DEATH <b>45 min.</b> <b>years</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <b>AUG. 1958</b> to <b>JAN. 16, 1959</b> , that I last saw the deceased alive on <b>JAN 16, 1959</b> , and that death occurred at <b>4:50 AM</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Donald F. Bartley</b> M.D.				ADDRESS (Street, city or town, state) <b>9 N. HANSON ST. EASTON MD</b>			
DATE SIGNED <b>1-16-59</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				22b. DATE THEREOF <b>Jan. 19, 1959</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Spring Hill Cemetery</b>	
22d. LOCATION (City, town, or county) (State) <b>Easton, Maryland</b>							
23. FUNERAL DIRECTOR'S SIGNATURE <b>Maurice E. Newnam &amp; Son</b> ADDRESS <b>Easton, Maryland</b>				24a. REC'D BY REGISTRAR <b>JAN 21 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the general director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED JAMES H. HARRIS		SEX Male		AGE 65 YRS.		RACE White		DATE OF BIRTH JAN 15 1897		PLACE OF BIRTH BALTIMORE, MD	
OCCUPATION Carpenter		EDUCATION High School		MARRIAGE Married		RELIGION Roman Catholic		DATE OF MARRIAGE JUN 15 1920		PLACE OF MARRIAGE BALTIMORE, MD	
CAUSE OF DEATH Myocardial Infarction		MANNER OF DEATH Natural		DATE OF DEATH JAN 15 1963		PLACE OF DEATH BALTIMORE, MD		HOURS OF DEATH 10:00 AM		DATE OF REPORT JAN 16 1963	
SIGNATURE OF PHYSICIAN J. H. HARRIS		SIGNATURE OF WITNESSES J. H. HARRIS		SIGNATURE OF DECEASED J. H. HARRIS		SIGNATURE OF NEXT OF KIN J. H. HARRIS		SIGNATURE OF CLERK J. H. HARRIS		SIGNATURE OF REGISTRAR J. H. HARRIS	

1148

## CERTIFICATE OF DEATH

Reg. Dist. No.

01159

1. PLACE OF DEATH o. COUNTY <b>TALBOT</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>MARYLAND</b> b. COUNTY <b>TALBOT</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>EASTON</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>EASTON</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>9 S. WASHINGTON ST.</b>		e. STREET ADDRESS <b>126 S. WASHINGTON ST</b>	
3. NAME OF DECEASED (Type or print) First <b>ABRAM</b> Middle <b>SEYDEL</b> Last <b>WISEL</b>		4. DATE OF DEATH Month <b>JAN.</b> Day <b>22</b> Year <b>1959</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>MAY 24, 1899</b>
9. AGE (In years last birthday) <b>59</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>TAYLOR</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>RUSSIA</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>MOSES WISEL</b>		14. MOTHER'S MAIDEN NAME <b>Not Known</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>MRS. CHARLOTTE WISEL</b>		Address <b>126 S. WASH. ST EASTON, MD</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.1 Acute Myocardial Infarction</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Coronary Occlusion</b> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <b>30 min.</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Essential Hypertension</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>June 1955</b> to <b>Jan. 22, 1959</b> , that I last saw the deceased alive on <b>Jan. 22, 1959</b> , and that death occurred at <b>6 P. M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>9 N. HANSON ST. EASTON, MD.</b> DATE SIGNED <b>1-22-59</b>			
ACTUAL SIGNATURE <b>Donald F. Bartley</b>		PHYSICIAN'S NAME (Type) <b>DONALD F. BARTLEY, M.D. EASTON, MD.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	22b. DATE THEREOF <b>1-25-59</b>	22c. NAME OF CEMETERY OR CREMATORY <b>ARLINGTON</b>	22d. LOCATION (City, town, or county) (State) <b>BALTO. MD</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Jack Lewis Inc - 2100 Eutan Place</b>		24a. REC'D BY REGISTRAR <b>JAN 26 '59</b>	24b. REGISTRAR'S SIGNATURE <b>Arthur L. K...</b>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the registrar, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



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STATE OF MARYLAND DEPARTMENT OF HEALTH—BALTIMORE, 18

1149

Item 9 Film 6237 1-21-59 et

CERTIFICATE OF DEATH

01160

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Calbot</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>Caroline</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>EASTON</u>		c. LENGTH OF STAY IN 1b <u>38 hr.</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Denton</u>		d. STREET ADDRESS <u>R7 D#1</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Memorial Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Thomas</u> Middle <u>H.</u> Last <u>WYATT</u>		4. DATE OF DEATH Month <u>JAN</u> Day <u>10</u> Year <u>1959</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MAY 1883</u>
9. AGE (In years last birthday) <u>75</u> yrs.		IF UNDER 1 YEAR Months <u>7</u> Days <u>16</u> Hours <u>16</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>John Wyatt</u>		14. MOTHER'S MAIDEN NAME <u>unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>1-14-59</u>	
17. INFORMANT <u>Bursley Wyatt, Federalburg, Md</u>		Address <u>Federalburg, Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Strangled Remained in pool, it</u> <u>5610</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>2 days</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diabetes</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1-8</u> , 19 <u>59</u> , to <u>1-10</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>1-10</u> , 19 <u>59</u> , and that death occurred at <u>9:24</u> A.M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Arthur B. Cecil</u> M.D.		ADDRESS (Street, city or town, state) <u>Easton, Md</u>	
PHYSICIAN'S NAME (Type) <u>Arthur B. Cecil</u>		DATE SIGNED <u>1-14-59</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Jan 13 59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Denton</u>		22d. LOCATION (City, town, or county) (State) <u>Denton Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. L. Moore &amp; Son</u> ADDRESS <u>Denton</u>		24a. REC'D BY REGISTRAR DATE <u>JAN 19 59</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur B. Cecil</u>			

# CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

Reg. Dist. No.

1. PLACE OF DEATH		2. QUALIFICATION OF REGISTRAR	
3. PLACE OF BIRTH		4. PLACE OF DEATH	
5. NAME OF DECEASED		6. SEX	
7. AGE		8. DATE OF BIRTH	
9. DATE OF DEATH		10. TIME OF DEATH	
11. CAUSE OF DEATH		12. MANNER OF DEATH	
13. PLACE OF INTERMENT		14. NAME OF INTERMENT	
15. SIGNATURE OF REGISTRAR		16. SIGNATURE OF DECEASED	
17. SIGNATURE OF WITNESS		18. SIGNATURE OF DECEASED	
19. SIGNATURE OF WITNESS		20. SIGNATURE OF DECEASED	
21. SIGNATURE OF WITNESS		22. SIGNATURE OF DECEASED	
23. SIGNATURE OF WITNESS		24. SIGNATURE OF DECEASED	
25. SIGNATURE OF WITNESS		26. SIGNATURE OF DECEASED	
27. SIGNATURE OF WITNESS		28. SIGNATURE OF DECEASED	
29. SIGNATURE OF WITNESS		30. SIGNATURE OF DECEASED	
31. SIGNATURE OF WITNESS		32. SIGNATURE OF DECEASED	
33. SIGNATURE OF WITNESS		34. SIGNATURE OF DECEASED	
35. SIGNATURE OF WITNESS		36. SIGNATURE OF DECEASED	
37. SIGNATURE OF WITNESS		38. SIGNATURE OF DECEASED	
39. SIGNATURE OF WITNESS		40. SIGNATURE OF DECEASED	
41. SIGNATURE OF WITNESS		42. SIGNATURE OF DECEASED	
43. SIGNATURE OF WITNESS		44. SIGNATURE OF DECEASED	
45. SIGNATURE OF WITNESS		46. SIGNATURE OF DECEASED	
47. SIGNATURE OF WITNESS		48. SIGNATURE OF DECEASED	
49. SIGNATURE OF WITNESS		50. SIGNATURE OF DECEASED	
51. SIGNATURE OF WITNESS		52. SIGNATURE OF DECEASED	
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91. SIGNATURE OF WITNESS		92. SIGNATURE OF DECEASED	
93. SIGNATURE OF WITNESS		94. SIGNATURE OF DECEASED	
95. SIGNATURE OF WITNESS		96. SIGNATURE OF DECEASED	
97. SIGNATURE OF WITNESS		98. SIGNATURE OF DECEASED	
99. SIGNATURE OF WITNESS		100. SIGNATURE OF DECEASED	